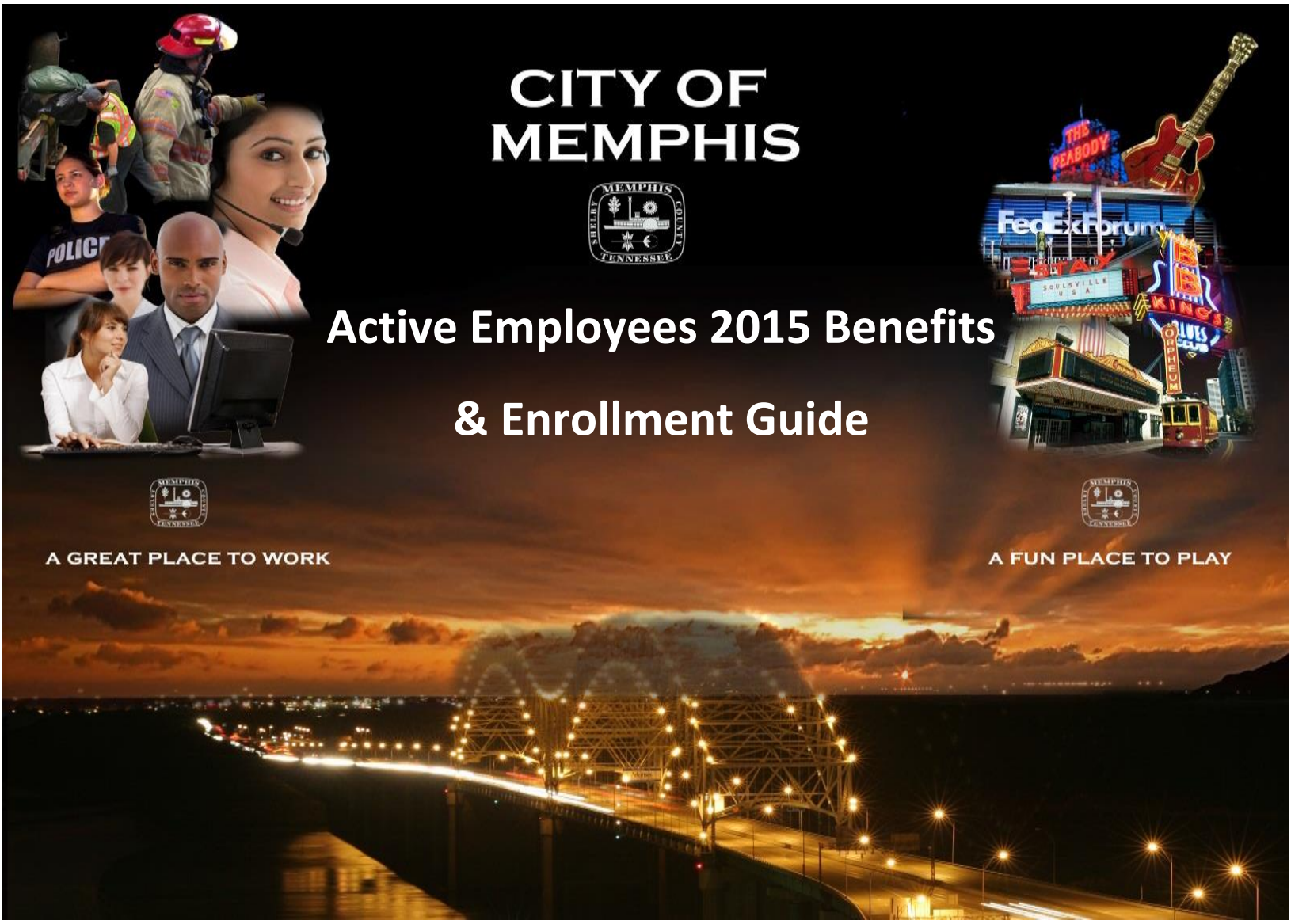

ACTION REQUIRED (OPEN IMMEDIATELY)

Open Enrollment October 6-17, 2014

"Don't wait in line, enroll online"

http://openenrollment.memphistn.gov

The City of Memphis is pleased to offer a comprehensive benefits package to all full-time employees that is designed to help protect you and your family's health, finances, and lifestyle. This guide not only summarizes your benefits for 2015 but it gives you an overview of all the benefits available to you as a City of Memphis employee. Reviewing the information contained in this guide will help you make informed decisions about your benefit elections.

Health Wellness and Benefits has taken every effort to ensure the accuracy of the information provided in this guide. However, if there is a conflict with any plan or benefits policy, the plan policy will always govern.

City of Memphis reserves the right to amend, suspend or terminate the benefit plans at any time.

WHAT IS IN THIS DOCUMENT?

Important information for 2015 Open Enrollment:

- The 2015 open enrollment period for active employees starts **October 6, 2014** and will end at midnight **October 17, 2014. Everyone must submit the necessary Nicotine and Working Spouse Verifications. If you fail to submit the Verifications, you will incur the Nicotine Surcharge and your covered spouse may be terminated from the Plan.** Copies of the Verifications are contained in the Appendix or may be obtained on-line.
- No waiting in long lines with benefit online enrollment.
- If no changes are made to your Dental, Vision, or Life Insurance, your current elections will roll over to 2015.
- You **cannot roll over** your current elections for Flexible Spending Accounts (FSAs). You must re-enroll each year in order to continue either of these plans.
- To make benefit changes or to enroll in an FSA for 2015, you must do so during Open Enrollment. You can enroll in one of three ways:
    - Enroll online through the City's Open Enrollment web portal @ **http://openenrollment.memphistn.gov.**
    - Mail your completed enrollment form along with required documentation to the Health Wellness and Benefits Office. Any enrollment forms submitted by mail must be post marked no later than October 17, 2014.
    - Visit the Health Wellness and Benefits Office at 2714 Union Ext., 5th Floor, Suite 100, Memphis, TN 38112.
- Summaries of Benefits and Coverage (SBCs), as required by the Patient Protection Affordable Care Act (PPACA) are either available online or you can request a hardcopy by calling Health Wellness and Benefits at (901) 636-6800.

Remember you can only make changes during open enrollment unless you have a qualifying life event such as the birth of a child or you get married or divorced. See the Medical Summary Plan Description for complete details of qualifying life events.

What's New for 2015?

- There are three (3) open enrollment periods:
    - Active Employees: October 6, 2014 to October 17, 2014
    - Retirees Age 65 and Older: November 3, 2014 to November 14, 2014
    - Retirees Under Age 65: November 10, 2014 to November 21, 2014.

  If more than one open enrollment period is applicable to you and your family, the appropriate open enrollment period is based on the status of the primary member.
- There is now an annual Out of Pocket (OOP) Maximum for prescription drugs which all copays, coinsurance and deductibles count toward.
- There is an increase in dental premiums.
- The City is expanding the scope of the tobacco surcharge to include all nicotine products, including, cigarettes, chewing tobacco, snuff and vaporized cigarettes which contain nicotine.
- The Nicotine surcharge will increase from $50 per month per family to $120 per month per family.
- The City will implement a working spouse rule which excludes from participation in the City's medical plan any participant's spouse who has access to insurance through an employer, Medicare or a former employer.
- All participants who become eligible to enroll in Medicare Part A & B must enroll in both parts. If a participant fails to enroll or allows coverage to lapse, for any reason, the participant shall be treated as if Parts A & B are available.
- Remember you must submit the Nicotine and Working Spouse Verifications. If you fail to submit the Verifications, your spouse will be dropped from coverage and you will incur the $120 monthly Nicotine Surcharge.

HOW TO ENROLL

- **SELF SERVICE:**

  Enrolling online is the ultimate choice for your 2015 enrollment elections. You can view your current benefits, make benefit changes or enroll in the available benefit options. During the open enrollment period, the online system is available 24/7 and can be accessed from work or any computer with internet access. Further, if your online enrollment confirmation states additional information is needed in order to finalize your enrollment, please fax the documentation to 901-636-8486. Remember to keep a copy of your benefits online confirmation statement.

- **MAIL/FAX/E-MAIL:**

  Mail your completed enrollment form along with any required documentation to City of Memphis, Health Wellness and Benefits, 2714 Union Avenue Ext., 5th Floor, Room 100, Memphis, TN 38112. All mail must be postmarked no later than October 17, 2014. Enrollment forms can also be faxed to 901-636-8486 or 901-636-6442 or e-mailed to benefitsmemphis.com. If you are faxing information, please keep a copy of your fax confirmation page for your records as well.

  NOTE: If you need to change information previously submitted during this Open Enrollment period, note the changes and submit the corrected information to the Benefits Office.

- **IN PERSON:**

  Visit the Health, Wellness and Benefits Office, 2714 Union Avenue Ext., 5th Floor, Room 100, Memphis, TN 38112 between 8:00 am and 5:00 pm.

All 2015 changes will be reflected in your first paycheck in December. Please refer to the rates listed in this guide to determine the correct deductions. You must notify Health Wellness and Benefits immediately but no later than 30 days after your first paycheck in December if there are discrepancies. If you fail to do so, the City may not be able to remedy your problem until you re-enroll during the next open enrollment.

Who is Eligible for benefits?

You are eligible for benefit programs if you are a regular, full-time employee. You may also enroll your spouse and dependent children who meet the definition of eligibility as defined below for health care and/or life insurance benefits.

- You may enroll your dependent children including legally adopted and step children up to age 26.
- Spouse Coverage in the Medical Benefit Program - You may NOT insure your spouse with medical coverage if his or her current or former employer provides medical coverage or if your spouse is eligible for Medicare Part A & B, unless your spouse is also an employee of the City of Memphis. In order for your spouse to remain an eligible participant of your plan, a Verification signed by you and your spouse stating your spouse does not have access to health insurance coverage from a current or former employer or does not have access to Medicare Parts A & B. *Even if you previously submitted an Affidavit attesting to that your spouse does not have access to insurance through an employer, a new Verification signed by both you and your spouse must be received during Open Enrollment. Failure to submit an executed Spousal Verification will result in your spouse being ineligible to participate in the City's medical plan in 2015.*
- You may still insure your spouse under the dental, vision and life benefits.

Required Documentation to add an additional participant to your Plan

Eligible	*Required Documentation*
Regular full-time employees	N/A
Lawful Spouse of the opposite sex	✓ A Verification signed by you and your spouse stating that your spouse does not have access to health insurance coverage from a current or former employer and does not have access to Medicare Parts A & B. ✓ Copy of Marriage License, (unless previously submitted) ✓ Copy of Social Security Card (unless previously submitted) ✓ Date of Birth (unless previously submitted)
Dependents to Age *26 (child who is married or unmarried and is your biological, legally adopted, or stepchild of you and/or your spouse.) *life insurance plans cover dependents to age 19 (25 if a full-time student).	✓ Copy of Birth Certificate listing you as the parent, or ✓ Copy of the Adoption Agreement, or ✓ Copy of court papers showing custody/guardianship, or ✓ Copy of divorce decree showing the dependent, or ✓ Copy of Qualified Medical Court Support Order (QMCSO) and ✓ Copy of Social Security Card

Medical Plan Options - Comparison Chart/Semi-Monthly Active Employee Rates

The following are brief highlights of the major plan provisions for the City of Memphis medical plans administered by Cigna Healthcare. You must refer to the Summary Plan Description (SPD) for applicable benefit limits and details regarding the plans.

	Basic Plan **Single: $100.45** **Family: $213.25**		**Premier Plan** **Single: $108.98** **Family: $220.13**		**Value Plan** **Single: $46.00** **Family: $182.90**	
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
ANNUAL DEDUCTIBLE	$ 350 Sgl $1,050 Fam	$ 350 Sgl $1,050 Fam	$100 Sgl $300 Fam	$500 Sgl $1,500 Fam	$1,500 Sgl $3,000 Fam	N/A
CO-INSURANCE ***(Hospital and Other Services)***	**You:** 10% **Plan:** 90%	**You:** 30% **Plan:** 70%	**You:** 0% **Plan:** 100%	**You:** 40% **Plan:** 60%	**You:** 30% **Plan:** 70%	N/A
ANNUAL OUT OF POCKET (OOP) MAXIMUM-MEDICAL	**You:** $1,500 Sgl/$3,000 Fam	**You:** $3,500 sgl/$7,000 fam	**N/A**	**You:** $3,000 sgl/$7,000 fam	**You:** $3,000 Sgl/$6,000 Fam	N/A
ANNUAL OUT OF POCKET RX (OOP) MAXIMUM-RX	**$2000 Sgl** **$4000 fam**	**$4000 Sgl** **$8000 fam**	**$2000 Sgl** **$4000 fam**	**N/A**	**$2000 Sgl** **$4000 fam**	**N/A**
OFFICE VISIT AND HOSPITAL: Primary Care Physician (PCP)/ Specialist Inpatient Hospital Copay per Admission Urgent Care Copayment *Emergency Room Copayment *Waived if Admitted	**You:** 10% after Ded. **Plan:** 90% **You:** $100 copay + Ded. + 10% **Plan:** 90% **You:** $25 copay + Ded. + 10% **Plan:** 90% **You:** $100 copay + Ded. + 10% **Plan:** 90%	**You:** 30% after Ded. **Plan:** 70% **You:** $300 copay + Ded. + 30% **Plan:** 70% **You:** 30% after Ded. **Plan:** 70% **You:** 30% after Ded. **Plan:** 70%	**You:** $20 copay PCP/$40 Spec + Ded **Plan:** 100% **You:** $100 copay + Ded. **Plan:** 100% **You:** You pay $30 + Ded. **Plan:** 100% **You:** $200 copay + Ded. **Plan:** 100%	**You:** 40% after Deductible **Plan:** 60% **You:** $300 copay + Ded. + 40% **Plan:** 60% **You:** 40% after deductible **Plan:** 60% **You:** 40% after deductible **Plan:** 60%	**You:** 30% after Ded. **Plan:** 70% **You:** $100 Copay + Ded. + 30% **Plan:** 70% **You:** 30% after Ded. **Plan:** 70% **You:** $200 copay + Ded + 30% **Plan:** 70%	N/A N/A N/A
PREVENTIVE CARE: *Well Child Office *Well Adult Visit ***Ded/Copay does not apply**	**You:** $0 **Plan:** 100% **You:** $0 **Plan:** 100%	NOT COVERED NOT COVERED	**You:** $0 **Plan:** 100% **You:** $0 **Plan:** 100%	Not Covered Not Covered	**You:** $0 **Plan:** 100% **You:** $0 **Plan:** 100%	N/A N/A
OTHER CARE: Chiropractic Care (limited to 20 visits/cal yr) Physical/Speech/ Occupation Therapy (limited to 60 days for all therapies) Durable Medical Equipment (DME)	**You:** 10% after deductible **Plan:** 90% **You:** 10% after deductible **Plan:** 90% **You:** 10% after deductible **Plan:** 90%	NOT COVERED NOT COVERED **You:** 30% after deductible **Plan:** 70%	**You:** $40 copay + Ded. **Plan:** 100% **You:** $40 copay + Ded. **Plan:** 100% **You:** Deductible **Plan:** 100%	Not Covered **You:** 40% after plan deductible **Plan:** 60% Not Covered	**You:** 30% after deductible **Plan:** 70% **You:** 30% after deductible **Plan:** 70% **You:** 30% after deductible **Plan:** 70%	N/A N/A N/A
Mental Health/Substance Abuse:	Same as office, medical, and hospital care.	Same as office, medical, and hospital care.	Same as office, medical, and hospital care.	Same as office, medical, and hospital care.	Same as office, medical, and hospital care.	NOT COVERED

Nicotine Surcharges

In addition to the medical premium, a nicotine surcharge will apply if you or any of your covered family members use nicotine products.

To have the nicotine surcharge waived, you must complete and sign a Verification during open enrollment attesting that neither you or any of your covered family members is a nicotine user. ***Even if you previously submitted an Affidavit attesting to the non-use of tobacco products by your covered family members, a new Verification must be received during Open Enrollment. Failure to do so will result in the assessment of the surcharge until you and your appropriate family members can provide negative test results.***

Important Note: Signed affidavits waiving spouse and/or tobacco surcharges are subject to random audits that can result in disciplinary action including termination of healthcare coverage if findings show document falsification.

Prescription Drug Coverage

The City's pharmacy program is administered by CVS Caremark and is bundled with the medical plan. If you enroll in medical, you are automatically enrolled in pharmacy and cannot opt out of the program. Also, you cannot elect to enroll in pharmacy only.

The Pharmacy benefit includes both retail and voluntary mail order for maintenance drugs prescribed for 90-day therapy. These medications can be purchased at a more reasonable cost to you by offering a three month supply for two months in copayments. See below benefits:

	Generic	***Formulary Brand** (PDL-Preferred Drug List)	**Non-Formulary Brand**
	Copays apply after satisfying the $25 annual deductible		
Retail (30 day supply)	$10.00 copay	$20.00 copay	$40 copay
Retail or Mail Order (90 day supply)	$20 copay	$40 copay	$80 copay
***The preferred drug list is updated quarterly and can be found on Caremark's website. See vendor contact listing in this guide. Additional pharmacy detail is listed on Benefit's website.**			

Vision Comparison Chart/Semi-Monthly Rates

The City of Memphis vision plans are administered by UnitedHealthcare (UHC). The below chart is a summary of the benefits offered. Visit UHC's website at www.myuhc.com for a listing of the vision providers or you may contact their customer service at the phone number listed in the vendor contact section of this guide. For complete vision plan details, visit Health Wellness and Benefits website.

	Exam and Materials **Employee: $2.30** **Employee + 1: $4.21** **Employee + Family: $7.15**	**Materials Only** **Employee: $1.70** **Employee + 1: $3.13** **Employee + Family: $5.30**
Comprehensive Vision Exam	$15 Copay (once every 12 months)	Not Covered
Materials (The materials copay is a single payment that applies to the entire purchase of eyeglasses (lenses and frames), or contacts in lieu of eyeglasses).	$15 Copay • Pair of lenses for eyeglasses (Once every 12 months) • Frames (Once every 24 months) • Contact Lenses in lieu of Eyeglasses (Once every 12 months)	$15 Copay • Pair of lenses for eyeglasses (Once every 12 months) • Frames (Once every 24 months) • Contact Lenses in lieu of Eyeglasses (Once every 12 months)

Dental Comparison Chart/Semi-Monthly Rates

The chart below is an overview of the dental plans offered by United Healthcare (UHC). Complete plan details can be found online. Please visit UHC's website, as listed in the vendor contact section of this guide, for a listing of network dental providers.

	Primary Dental Plan **Employee: $8.53** **Employee + 1: $16.96** **Employee + Fam: $31.38**		**Basic Dental Plan** **Employee: $9.72** **Employee +1: $20.00** **Employee + Fam: $29.11**		**Premier Dental Plan** **Employee: $14.64** **Employee +1: $30.11** **Employee + Fam: $43.81**	
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Annual Individual Ded.	None	None	$50	$100	$50	$50
Annual Family Ded.	None	None	$150	$300	$150	$150
Annual Ind Orthodonics Ded.	None	None	$50	$100	$50	$50
Annual Fam Orthodonics Ded.	None	None	$150	$300	$150	$150
Maximum Non-Orthodontics *(combined for both In Network and Out of Network Services).*	$1500 per person per calendar year	$1500 per person per calendar year	$1000 per person per calendar year	$750 per person per calendar year	$1000 per person per calendar year	$1000 per person per calendar year
Maximum Orthodontics (combined for both In Network and Out of Network Services	$1000 per person per lifetime	$1000 per person per lifetime	$500 annual max; $1000 per person per lifetime	$375 annual max; $750 per person per lifetime	$500 annual max; $1000 per person per lifetime	$500 annual max; $1000 per person per lifetime
COVERED SERVICES	**You Pay**	**You Pay**	**Plan Pays**	**Plan Pays**	**Plan Pays**	**Plan Pays**
PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES						
Periodic Oral Examinations	$0	100%	100%	80%	100%	100%
Bitewing X-rays	$0	100%	100%	80%	100%	100%
Complete Series or Panorex X-rays	$0	100%	100%	80%	100%	100%
Dental Prophylaxis (Cleanings)	$0	100%	100%	80%	100%	100%
Fluoride Treatments	$0	100%	100%	80%	100%	100%
Sealants	$0	100%	100%	80%	100%	100%
BASIC DENTAL SERVICES *(Minor Restorative, Endodontics and Oral Surgery)*						
Space Maintainers	$100	100%	80%	60%	80%	80%
Palliative Treatment (Pain Relief)	$35	$35	80%	60%	80%	80%
General Anesthesia	$115	100%	80%	60%	80%	80%
Amalgam Restorations (Fillings)	$40	100%	80%	60%	80%	80%
Composite Restorations (Fillings)	$47	100%	80%	60%	80%	80%
Surgical Extractions including Impacted Wisdom Teeth	$145	100%	80%	60%	80%	80%
Root Canal Treatment	$235	100%	80%	60%	80%	80%
Scaling and Root Planning	$70	100%	50%	40%	50%	40%
Periodontal Surgery	$339	100%	50%	40%	50%	50%
MAJOR DENTAL SERVICES *(Including Periodontics)*						
Crowns	$380	100%	50%	40%	50%	50%
Inlays	$310	100%	50%	40%	50%	50%
Fixed Bridges	$380	100%	50%	40%	50%	50%
Full Dentures	$440	100%	50%	40%	50%	50%
Partial Dentures	$440	100%	50%	40%	50%	50%
Replacement Crowns	$25	100%	50%	40%	50%	50%
Relining Dentures	$100	100%	50%	40%	50%	50%
Repairs to Full Dentures	$65	100%	50%	40%	50%	50%
ORTHODONTIC SERVICES						
Diagnose or correct misalignment of the teeth or bite	50%	50%	50%	40%	50%	50%

Flexible Spending Account (FSA)

The Flexible Spending Account (FSA) plans are administered by Cigna Healthcare and offers all City of Memphis regular full-time employees the opportunity to enroll. Enrollment in medical is not required in order to participate in an FSA. Only health care expenses that are considered tax-deductible by the IRS and not covered by insurance are eligible for reimbursement. When you enroll in an FSA plan, you decide in advance how much you would like to set aside from each paycheck before taxes are deducted. For every dollar you contribute to your FSA, you reduce your taxable income by that same amount. You do not pay taxes on the money you set aside. This money is available to you to use all year long to pay eligible expected and unexpected out-of-pocket healthcare or dependent expenses. It is important that you accurately determine anticipated annual expenses because there is a "Use-it" or "Lose-it" policy in effect. There is a grace period in which to use all the funds for the 2015 plan year. The grace period is until March 15, 2016. Your funds will be forfeited if not used by the end of the grace period. Remember you must enroll and specify each year the amount you would like to allocate for FSA. See the below chart for additional information:

	Healthcare FSA	Dependent Care FSA
You can contribute…	$200 - $2,500 annually	$200 - $5,000 annually
To reimburse yourself… **NOTE:** *After enrollment, the employee only will receive a debit card that can be used like cash at any vendor that accepts health care debit cards. The card can be used for expenses incurred by the employee, spouse or dependents.* *OR* *File a claim for reimbursement*	***Example of eligible expenses*** *(refer to www.irs.gov, pub 502 for a detailed list):* • Medical expenses including deductibles, coinsurance, copayments • Prescription deductibles, copayments • Dental expenses • Over-the-counter medicines, vitamins and supplements if prescription written • Over-the counter health related supplies	***Example of eligible expenses*** *(refer to www.irs.gov, pub 503 for a detailed list):* • Day care and associated expenses for your children under age 13 • Dependent care fees for a disabled spouse, child or a tax-dependent parent or elderly person
Plan Year	January - December 2015	January – December 2015
Grace Period	Until March 15, 2016	Until March 15, 2016
Claim Filing Deadline	March 31, 2016	March 31, 2016

Life Insurance

The City of Memphis offers a death benefit to all regular full-time employees at no cost to you. The following options are available for you to purchase additional life insurance coverage for you and your dependents….plan administered by Lincoln Financial Group:

- **Employee Contributory Life** – Coverage amount is based on annual salary and premium cost is shared between you and the City. Guarantee Issue is $200,000.
- **Spouse/Dependent Contributory Life** – Can elect $10,000 for Spouse and Dependent children at a monthly cost of $2.15 and the premium is paid by you; the employee.
- **Employee Voluntary Life** – Can elect $10,000-$500,000 in $10,000 increments. Guarantee Issue amount is the lesser of $200,000 or 3 times your salary if you are under age 60; $10,000 if you are age 60-69. Cost is based on age and the amount of coverage elected and is payable by you; the employee.

- **Spouse Voluntary Life** – Can elect $5,000-$250,000 in $5,000 increments. Premium is based on employee's age and the amount of coverage elected for the spouse. There is no cost sharing for this benefit between you and the City.
- **Dependent Voluntary Life** –Dependents can have $10,000 in coverage at a cost of $2.00 per month. There is no cost sharing.

NOTE: You can only elect contributory life and/or voluntary life for your spouse and dependents if you are electing the coverage for yourself.

Please refer to Health Wellness and Benefits website for additional Contributory and Voluntary life details as well as the calculation method if selecting more than $100,000 in Voluntary Life coverage or if you are age 65 or older.

Beneficiary for Life Insurance

Some insurance companies require an original signed beneficiary form in order to pay benefits should you die. Because of this requirement, beneficiary updates are no longer available online. You can however, print the form, complete and return it to City of Memphis Health Wellness and Benefits. Please make sure there is a signed form in Health Wellness and Benefits to ensure the person you planned to designate as your beneficiary receives the proceeds should something happen to you. **Important Note:** If you do not name a beneficiary, your life insurance proceeds will either go to your estate or the insurance company will follow their standard procedure for payouts. It is also important to note that the insurance company ***will not make a payment to a minor (anyone under the age of 18)*** who is named as the beneficiary. If you intend to list a minor, you should seek advice on estate planning before you complete this step.

Employee Voluntary Life Premiums

Please refer to Health Wellness and Benefits website for premium rate chart if you are electing employee or spouse voluntary life insurance.

Short Term Disability (STD) / Long Term Disability (LTD) – Administered by The Standard

Through the City's core benefit options you can elect Short Term Disability at the time of employment or a later date. You do not have to enroll during open enrollment or wait for a qualifying life event. However, if you enroll after your initial employment eligibility period, you must complete an Evidence of Insurability (EOI) form and coverage is not effective until approved by Standard's underwriters.

After you have completed your initial probationary period with the City of Memphis, you are automatically enrolled in Long Term Disability at no cost to you. Should you become disabled and go out on LTD, you are no longer considered an employee and will be removed from the City's payroll.

WELCOME TO WELLNESS WORKS – The Employees Suite of Wellness Services

Onsite Clinic

Are you or were you enrolled in the City's Medical Plan? Did you know the City has an onsite Clinic, operated by Methodist Healthcare, to provide wellness and urgent care services? If you are enrolled in one of the City's medical plans as of October 1, 2014, you may seek services at the clinic with no cost to you or any of your eligible dependents. The clinic will also have a limited supply of medications in stock at no cost to you or your dependents. ***If you are not currently enrolled in the City's Medical Plan or were not enrolled on October 1, 2014, this benefit is not available to you.*** The new onsite clinic is located at 1803 Union Ave. and is open Monday & Friday from 8:00 am to 4:00 pm and Tuesday, Wednesday & Thursday 11:00 am to 7:00 pm. The clinic will open for operations on October 1, 2014. Walk-ins at the clinic will be accepted however, appointments are preferred. The clinic can be reached at (901) 722-3177. ***NOTE: Take comfort in knowing your medical information is protected by HIPAA privacy laws and is not shared with The City of Memphis.***

24 Hour Nurseline – Cigna

What do you do when your child spikes a fever in the middle of the night? Or when you go jogging and twist your ankle? Don't worry, wonder or wait – whenever there's a question about health just call the Health Information Line and talk directly with a specialist trained as a nurse, 24 hours a day, 7 days a week. Dial the toll-free number on your Cigna ID card and speak one-on-one with a nurse for personalized attention and help answering your health questions.

Onsite Total Wellness Center

Have you been thinking of increasing your physical activity? Dreaming of shedding a few pounds or toning your physique? Stop dreaming and get moving….. You can become a member of the Total Wellness Center located at 125 North Main, on 2B in room 22. The center is equipped with free weights, elliptical machines, treadmills, exercise bikes and much more. The center is open Monday-Friday, 7:00 am – 7:00 pm (closed on weekends and City of Memphis holidays). To become a member of the Wellness Center, you must complete an enrollment application that includes health history, waiver forms and the policy and procedures. The next step is to schedule an appointment with the Wellness Coordinator for a health assessment and fitness center orientation. You may contact Health, Wellness and Benefits should you have questions or need additional information.

Cigna Wellness and Disease Management Programs

Why is Cigna calling me and should I answer? Through the medical benefits plans, various programs are included to help you get healthy and live well. Programs like Stress Management Weight Management, Tobacco Cessation, Case Management and Disease Management (Diabetes, Asthma, COPD, Low Back Pain, Hypertension, Heart, etc.) are designed to help you better manage your health. Cigna receives information about you from multiple sources such as claims, your health risk assessment, as well as alerts if you have missed your preventive care visit. At this point, Health Advocates are deployed to reach out to you. It is okay to answer the call as the conversations you have with your Health Advocates are completely private and confidential and is not shared with anyone at the City of Memphis. The Health Advocate will talk to you about the program(s) that will best benefit you in managing your health.

Who are Health Advocates? These are professionals trained as registered nurses, behavioral specialists, health educators, exercise specialists or nutritionists and they are all supported by doctors and pharmacists.

What if I don't receive a call, can I still join a program? Yes. You can call Cigna or go to their website. See contact information listed in the Vendor Contact section of this guide.

Employee Assistance Program (EAP) – Administered by Concern

Did you know the City offers EAP services to help you manage quality of life issues? This service is paid by the City and is available to you, your dependents or household members even if you are not covered by a City of Memphis medical plan option. Short-term professional assistance is available through CONCERN 24/7 by calling (901) 458-4000 or 1-800-445-5011.

YMCA Information

Employees can join the YMCA at any of the 9 facilities located throughout the City and have the *membership fee payroll deducted. The City of Memphis will provide $6 per month toward your YMCA membership, if you work out at least 8 times per month.

**Based on your household income, you may qualify for a membership discount. Eligibility determined by the YMCA.*

Vendor Contact Information

Benefit/Vendor	Phone	Website
General/Wellness		
Health Wellness and Benefits	901-636-6800 or Toll Free 1-866-543-4367	http://www.memphistn.gov (Click on Government Click on Human Resources Click on Health, Wellness, and Benefits) or http://openenollment.memphistn.gov
Medical		
Cigna Medical	1-800-Cigna24	www.mycigna.com
Pharmacy		
Caremark	1-866-722-2001	www.caremark.com
Dental		
United Healthcare Dental	1-866-540-5933	www.myuhcdental.com
Vision		
United Healthcare Vision	1-800-638-3120	www.myuhcvision.com
EAP		
Concern (Employee Assistance Program)	901-458-4000 or toll free 1-800-445-5011	www.concern-eap.com
Voluntary Plans		
AFLAC	Diane Bradley @ office: 901-761-8002/cell: 901-292-1568 or Bud Webb @ 901-866-2190	www.aflac.com
Colonial Life	901-507-8880	www.coloniallife.com
Deferred Compensation		
Nationwide Retirement Solutions	901-323-4154 901-323-4270	www.nrsretire.com

Legislative Notices

COBRA Rights for Employees and Dependents

Introduction

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;

- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days [after the qualifying event occurs. You must provide this notice to: Health Wellness and Benefits Office of the City of Memphis.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

City of Memphis, Health Wellness and Benefits Office at 2714 Union Ext., 5th Floor, Suite 100, Memphis, TN 38112

How much does COBRA cost for City-Sponsored plans?

	2015 MONTHLY COBRA MEDICAL RATES		
	Basic Plan	Premier Plan	Value Plan
Single	$581.40	$654.84	$516.12
Family	$1178.10	$1505.52	$1186.26

	2015 MONTHLY COBRA DENTAL RATES		
	Primary Plan	Basic Plan	Premier Plan
Employee	$17.40	$19.83	$29.87
Employee + 1	$34.60	$40.80	$61.42
Employee + Family	$64.02	$59.38	$89.37

	2015 MONTHLY COBRA VISION RATES	
	Exam and Materials	Materials Only
Employee	$4.70	$3.47
Employee + 1	$8.59	$6.39
Employee + Family	$14.68	$10.84

Women's Health and Cancer Rights Act (WHCRA)

As required by the Women's Health and Cancer Rights Act of 1998, the City of Memphis benefits plans provides for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Benefits are payable the same as any other medical or surgical benefit covered by your plan.

Newborns and Mother's Health Protection Act of 1996

Under federal law, group health plans and health insurance issuers offering health insurance coverage generally may not restrict benefits for hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after conclusion with the mother, discharges the mother or newborn earlier.

Medicaid and the Children's Health Insurance Program (CHIP)

Offer Free or Low-Cost Coverage to Children and Families

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

Important Notice About Your Prescription Drug Coverage and Medicare

The key purpose of this notice is to advise you that the prescription drug coverage you have under your City of Memphis medical plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay (This is known as "creditable coverage.").The reason this is important is that if you or a covered dependent are or become eligible for Medicare and you decide to enroll in a Medicare prescription drug plan during a subsequent annual enrollment period; you will not be subject to a late enrollment penalty as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment.

You should keep this notice with your important records.

Notice of Creditable Coverage
Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Memphis and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:
1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. City of Memphis has determined that the prescription drug coverage offered by the health plan is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, you and your dependents will no longer be eligible for the City of Memphis drug plan. Be aware eligibility for the City of Memphis drug plan is lost forever; you will not be able to get the coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with City of Memphis and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go

nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

City of Memphis, Health Wellness & Benefits Office
2714 Union Avenue Ext., 5th Floor, Room 100
Memphis, TN 38112
(901) 636-6800 or (866)-543-4367

NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Memphis changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. **For more information about Medicare prescription drug coverage: Visit www.medicare.gov; Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help; or Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.**

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Notice of Privacy Practices

Changes to this Notice

The Plan reserves the right to change this Notice at any time and to make the revised or changed Notice effective for health information the Plan receives in the future. If the Plan changes its policies and practices, the Plan will revise this Notice and will provide a copy of the revised Notice to you within 60 days of the change. The Plan will post a copy of the current Notice on the City of Memphis Human Resources webpage.

Filing a Complaint

If you believe your privacy rights have been violated, you may file a written complaint with our Compliance Official at the address below.

HIPAA Compliance Officer
Human Resources Division
2714 Union Avenue Ext., 5th Floor, Suite 100
Memphis, TN 38112
(901) 636-6574

Complaint forms are available on the COM intranet. You may also file a complaint with the Secretary of Health and Human Services within 180 days of when the act or omission complained occurred. There will be no retaliation for filing a complaint with the COM or the Secretary of Health and Human Services.

Contact Information

To obtain access, amend, or receive an accounting of disclosures of your PHI or receive a paper copy of this Notice you may contact the Plan's Benefit Manager at the address below:

Benefits Manager
COM Employee Group Health Plan
2714 Union Avenue Ext., 5th Floor, Suite 100
Memphis, TN 38112
(901) 636-6479

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the City of Memphis (COM) Employee Benefit Health Plan (medical/surgical and mental health/substance abuse programs and prescription programs, collectively referred to as the Plans') to notify plan participants about its practices to protect the confidentiality of their protected health information (PHI). PHI is any information that may identify you and that relates to your past, present, or future physical or mental health condition and any related health care services and payment for those health care services. This Notice describes how the Plans may use and disclose PHI to carry out treatment, payment, or health care operations or other specified purposes permitted or required by law. The Notice also provides you information about your rights to access, to amend, and control the disclosure of your PHI.

The City of Memphis Health Plan is required to abide by the terms of this Notice, but reserve the right to change the Notice at any time. Any change in the terms of this Notice will be effective for all PHI that the Health Plan maintains at that time. If a change is made to this Notice, a copy of the revised Notice will be provided to all individuals covered under the Health Plan at that time.

Effective Date: April 14, 2003
Revised: January 26, 2013

USES AND DISCLOSURE OF YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

For Treatment. The Plans may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the Plans may advise an emergency room physician about the types of prescription drugs you currently take.

Uses and Disclosure for Payment. The Plans may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the Plan's terms. For example, the Plans may receive and maintain information about a surgery you received to enable the Plans to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf, or the Plans may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

Uses and Disclosure for Health Care Operations. The Plans may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the Plan's participants receive their health benefits. For example, the Plans may use and disclose your PHI for the Plans' administration activities such as quality assessments, case management, disease management programs, care coordination and other Plan-related activities including audits of claims.

Use and Disclosure to the Plan Sponsor. The Plans may disclose health information to City of Memphis, but City of Memphis has put protections in place to assure that the information will only be used for plan administration purposes, and never for employment purposes.

Individual Involved in Your Care or Payment. In limited circumstances, the plans may disclose your PHI to a close friend or family involved in or who helps pay for your health care. The Plans may also, upon request, advise a family member or close friend about your condition, your location (for example, inform an individual that you are in the hospital), or death. If you do not want such information to be shared with these individuals, you may request that these disclosures be restricted as provided in the section of this notice dealing with your rights.

Business Associate. Certain services are provided to the Plans by third party administrators or other vendors who are known as "business associates." The Plans may disclose your PHI to these business associates in connection with their services for the Plan. For example, the Plan may input information about your health care treatment into an electronic claims processing system maintained by the Plan's business associate so your claim may be paid. In so doing, the Plan will disclose your PHI to its business associate so it can perform its claims payment functions. However, the Plans will require its business associates, through contract, to appropriately safeguard the privacy of your health information. As well, HIPAA requires business associates to comply directly with many of the HIPAA provisions for safeguarding PHI.

USES AND DISCLOSURES PERMITTED
AND REQUIRED BY THE PLANS

The Plans may use or disclose your PHI for any purpose required by law. The Plans are required or permitted to use or disclose your PHI without your authorization under the following circumstances:

Public Health Risk. The Plans may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify participants of recalls of products they have been using.

Health Oversight Activities. The Plans may disclose your PHI to a health oversight agency for audits, investigations, inspections and licensure necessary for the government to monitor the health care system and government programs.

Judicial and Administrative Proceedings. If you become involved in a lawsuit or other legal action, the Plans may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.

Law Enforcement Purposes. The Plans may release your PHI if asked to do so by a law enforcement official. For example, to identify or locate a suspect, material witness, or missing person, or to report a crime, the crime's location or victims, or the identify, description, or location of the person who committed the crime.

Coroners, Medical Examiners, and Funeral Directors. The Plans may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Plans may also release your PHI to a funeral director, as necessary, to carry out his/her duty.

Organ/Eye/Tissue Donation. If you are an organ donor, the Plans may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

Certain Limited Research Activities. The Plans may disclose information to researchers when an Institutional Review Board has reviewed and approved the research proposal, established protocols to ensure the privacy of your health information and granted a waiver of the authorization requirement.

Health and Safety. The Plans may consistent with applicable law and standards of ethical conduct disclose your PHI if the Plans, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

Government Functions. The Plans may use and disclose your PHI for specialized government functions. For example, if you are in the Armed Forces or a veteran for purposes of certain national security; Presidential protection and intelligence activities.

Work-Related Illness and Injuries. The Plans may disclose your PHI to the extent authorized by and to the extent necessary to comply with City's On-the-Job Injury Program or others for the purposes related to employer occupational health and safety laws.

Communication related to your health. The Plans may use and disclose your PHI to provide information to you about disease management programs, treatment alternatives or other health-related benefits and services that may be of interest to you.

Fundraising and Marketing. The Plan will NOT use or disclose your PHI for fundraising or marketing purposes, as defined by HIPAA and its implementing regulations.

All other uses and disclosures of your protected health information will require your written authorization. This authorization will have an expiration date that can be revoked by you in writing. Certain uses and disclosures of psychotherapist notes will also require your written authorization.

YOUR INDIVIDUAL RIGHTS

Your rights regarding the health information the Plans maintain about you are as follows:

Right to Inspect and Copy. You have the right to inspect and copy your PHI maintained in a "designated record set", generally with thirty (30) days of your request. The designated record set consists of records used in making payment, claims adjudication, medical management and other decisions, but does not include psychotherapy notes. If your PHI is maintained by the Plans is in electronic format, you have the right to obtain a copy in electronic format and to direct that the Plan transmit the copy to an entity or person that you designate. The Plan may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

Right to Amend. If you believe that health information is incorrect or incomplete, you may ask the plans in writing to amend it. You have the right to request an amendment for as long as the information is kept by or for the Plans. You must provide the reason (s) to support your request. Generally, the Plans have sixty (60) days to respond to your request, advising you of whether the amendment has been accepted or denied and informing you of details relevant to the acceptance or denial of your request. The Plans may deny your request if you ask the Plans to amend health information that was: (1) accurate and complete; (2) not created by the Plan; (3) not part of the health information kept by the Plan; or (4) not information that you would be permitted to inspect or copy. If your request is denied, you have the right to submit a statement disagreeing with the denial. The Plans must keep a copy of your request for amendment and any statement disagreeing with the denial of the amendment with your PHI and must disclose such documents when it discloses the PHI that is the subject of the requested amendment.

Right to an Accounting of Disclosures. You have the right to request in writing an "accounting of disclosures." This is a list of disclosure of your PHI that the Plans has made to others, except for those necessary to carry out health care treatment, payment, or operations; disclosures made to you; or in certain other situations in accordance with HIPAA law and regulations. Your request must state a time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. Generally, the Plans have sixty (60) days to respond to your request. The Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Plan will inform you in advance of the fee, if applicable. If the Plans uses or maintains your PHI in an electronic health record (created by health care clinicians or staff and transferred to the Plan), you may have a right to an additional, limited accounting of disclosures of health records, in accordance with the amendments to HIPAA under the HITECH Act of 2009.

Right to Request Restrictions. You have the right to request in writing a restriction on the health information the Plans use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the Plans discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the Plana not use or disclose information about a surgery you had. You must advise the Plan: (1) what information you want to limit; (2) whether you want to limit the Plan's use, disclosure, or both; and (3) to whom you want the limit(s) to apply. **Note:** The Plans are not required to agree to your request, except in circumstances after February 2010 where you are requesting that PHI not be disclosed to a health plan for payment or health care operations if the PHI relates solely to a service or item for which you have paid for in full out of pocket.

Right to Request Confidential Communication. You have the right to request in writing that the Plans communicate with you regarding your health matters by alternative means or
at alternative locations. For example, you can ask that messages not be left on voice mail or sent to a particular address. Your request must specify that disclosure of all or part of the information could endanger you, how or where you wish to be contacted and, where applicable, how payment for this service will be handled. The Plan will accommodate all reasonable requests.

Breach Notification. You have a right to receive notification in the event the Plans discovers a breach of your unsecured Protected Health Information and determine notification is required by HIPAA.

Right to a copy of this Notice. You have the right to request a paper copy of this Notice at any time by sending a written request to the Benefit Manager at the address on the last page of this Notice. You may also read and download a copy from our website: www.cityofmemphis.org

FORMS

All-IN-ONE BENEFICIARY FORM

(Death Benefit, Contributory Life, Voluntary Life and Final Pay)

ALL-IN-ONE ENROLLMENT/CHANGE FORM

(Medical, Dental, Vision, FSA, Life & Short-Term Disability)

WORKING SPOUSE VERIFICATION

&

NICOTINE USAGE/NON-USAGE STATEMENT

CITY OF MEMPHIS LIFE INSURANCE
BENEFICIARY FORM
(Please check all that apply)

☐ **Death Benefit** ☐ **Contributory Life**

☐ **Voluntary Life** ☐ **Final Pay**

- -										
SOCIAL SECURITY #	**LAST**	**FIRST** EMPLOYEE NAME	**MIDDLE**	**MO**	**DAY**	**YR** DATE OF BIRTH	**MO**	**DAY**	**YR** DATE OF HIRE	**SEX**

IT IS YOUR RESPONSIBILITY TO KEEP YOUR BENEFICIARIES CURRENT.

*If a beneficiary is a minor, or if the benefit is payable to the estate it is required that a guardian or a legal representative be appointed prior to payment of the benefit.

Death Benefit Primary:

NAME, ADDRESS, TELEPHONE NUMBER OF BENEFICIARY(IES)	PERCENT	DATE OF BIRTH	SOCIAL SECURITY #	RELATIONSHIP TO EMPLOYEE (Spouse, parent, etc)
		/ /	- -	
		/ /	- -	

Contributory Life Primary:

NAME, ADDRESS, TELEPHONE NUMBER OF BENEFICIARY(IES)	PERCENT	DATE OF BIRTH	SOCIAL SECURITY #	RELATIONSHIP TO EMPLOYEE (Spouse, parent, etc.)
		/ /	- -	
		/ /	- -	

Voluntary Life Primary

NAME, ADDRESS, TELEPHONE NUMBER OF BENEFICIARY(IES)	PERCENT	DATE OF BIRTH	SOCIAL SECURITY #	RELATIONSHIP TO EMPLOYEE (Spouse, parent, etc.)
		/ /	- -	
		/ /	- -	

Final Pay Primary

NAME, ADDRESS, TELEPHONE NUMBER OF BENEFICIARY(IES)	PERCENT	DATE OF BIRTH	SOCIAL SECURITY #	RELATIONSHIP TO EMPLOYEE (Spouse, parent, etc.)
		/ /	- -	
		/ /	- -	

Note: If you wish to designate additional primary beneficiaries or designate contingent beneficiaries, please attach a separate sheet of paper and include your name, social security number and your date of birth. A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you.

I understand that the above named Beneficiar(ies) are for City of Memphis Life Insurance Polic(ies) and Final Pay Benefit.

_____ _____ _____
SIGNATURE **DATE** **TIME**

_____ _____
SIGNATURE OF BENEFITS REPRESENTATIVE **DATE**

City of Memphis

ACTIVE EMPLOYEE BENEFITS ENROLLMENT CHANGE FORM AND INSURANCE AFFIDAVIT

NOTE: **Complete ONLY if you elect to enroll in or change existing coverage. You must elect FSA each year during open enrollment in order to continue enrollment. All other benefits will continue unless you make a change. When completing the form, if you fail to make a selection, we will assume you are waiving the coverage and will not enroll you nor your dependents for that benefit.**

EMPLOYEE ACTION (please select one):

☐ Enroll in Benefits ☐ Cancel All Benefits ☐ Make Changes ☐ Add/Delete Dependents

A. EMPLOYEE INFORMATION

Social Security Number - -	City Oracle ID Number	Last Name First Name M.I.	Gender ☐ Male ☐ Female
Home Street Address Apt.#		Effective Date of Enrollment/Change:	Division Name
City, State, Zip		Date of Birth:	Hire Date:
Email Address:		Phone: ☐ Cell ☐ Home ☐ Work (_____) _____-_____	

B. REASON FOR ENROLLMENT/CHANGE

Check one Reason:

☐ I am a new hire ☐ I am enrolling during Annual Enrollment

☐ There has been a change in my family status (qualifying life event-QLE)*

***You must submit this form along with required documentation within 60 days of the event date.**

Please provide QLE and date of event _____ (Qualifying Life Events: Birth/Adoption, Marriage, Divorce or Legal Separation, Change in spouses employment, death, etc.

C. BENEFIT ELECTION (CHECK ONE PER BENEFIT)

Medical Plan	ENROLL: ☐ BASIC ☐ PREMIER ☐ VALUE ☐ CANCEL COVERAGE ☐ NO CHANGE ☐ WAIVE COVERAGE If waived, are you are covered by another plan. Yes or No If yes, please list name of insurance carrier _____	☐ EMPLOYEE ONLY ☐ EMPLOYEE + FAMILY
Dental Plan	ENROLL: ☐ BASIC ☐ PREMIER ☐ PRIMARY ☐ WAIVE ☐ CANCEL ☐ NO CHANGE	☐ EMPLOYEE ONLY ☐ EMPLOYEE + 1 ☐ EMPLOYEE + FAMILY
Vision Plan	ENROLL: ☐ EXAM & MATERIALS ☐ MATERIALS ONLY ☐ WAIVE ☐ CANCEL ☐ NO CHANGE	☐ EMPLOYEE ONLY ☐ EMPLOYEE + 1 ☐ EMPLOYEE + FAMILY
Flexible Spending Accounts (FSA)	HEALTH CARE FSA ($100-$2500) ☐ ANNUAL ELECTION AMOUNT:$_____ ☐ WAIVE/CANCEL COVERAGE	DEPENDENT CARE FSA ($100-5000) ☐ ANNUAL ELECTION AMOUNT:$_____ ☐ WAIVE/CANCEL COVERAGE
Short Term Disability Note: if you are enrolling after the first 31 days of your employment, evidence of insurability (EOI) is required	☐ ENROLL ☐ WAIVE COVERAGE ☐ CANCEL COVERAGE ☐ NO CHANGE	

BENEFIT ELECTION CONTINUED...

Contributory Life Note: if you are enrolling after the first 31 days of your employment, evidence of insurability (EOI) is required	You may purchase coverage at 1.5 times your annual base salary up to a maximum of $200,000. ☐ 1.5 times salary ☐ WAIVE COVERAGE ☐ CANCEL COVERAGE ☐ NO CHANGE
Contributory Dependent Life -$10,000 ea. (must enroll in contributory life in order to select dependent life)	$10,000 ea. (must enroll in contributory life in order to select dependent life) ☐ SPOUSE ☐ CHILDREN (6 months to 19 years) if student to age 25 ☐ WAIVE COVERAGE ☐ CANCEL COVERAGE ☐ NO CHANGE
Voluntary Note: if you are enrolling after the first 31 days of your employment, evidence of insurability (EOI) is required	(You may purchase in $10,000 increments with a guaranteed issue amount of $200,000 or 3 times your annual salary whichever is less. You will need to complete an evidence of insurability form for any amount above the guaranteed issue amount. We will mail the EOI form to you upon receipt of the enrollment form. Total coverage (guaranteed plus additional) cannot exceed $500,000 or 5 times your annual salary.) ☐ Amount Requested:$_________ ☐ WAIVE COVERAGE ☐ CANCEL COVERAGE ☐ NO CHANGE
Voluntary Spouse and Dependent Life (must enroll in voluntary life in order to select dependent life)	You may purchase life insurance for your spouse in increments of $5000 not to exceed 50% of your elected amount with a guaranteed amount of $30,000 if you are under age 60. You will need to complete an evidence of insurability form for any amount above the guaranteed issue amount. We will mail the EOI form to you upon receipt of the enrollment form. Total coverage (guaranteed plus additional) cannot exceed $250,000. ☐ Amount Requested for Spouse:$_________ ☐ CHILDREN (6 MONTHS TO AGE 19) TO AGE 25 IF FULL TIME STUDENT) ☐ WAIVE COVERAGE ☐ CANCEL COVERAGE ☐ NO CHANGE ☐

D. FAMILY MEMBERS TO BE COVERED - List all dependents to be covered. If you do not list a dependent, they will not be covered

LAST NAME	FIRST	M.I.	Social Security Number (Required	Date Of Birth	Check desired Action Medical	Dental	Vision	Employer Use Only:
Spouse:					☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel	Effective Date:
Child:					☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel	Effective Date:
Child:					☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel	Effective Date:
Child:					☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel	Effective Date:
Child:					☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel	Effective Date:
Child:					☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel	Effective Date:

E. OTHER INSURANCE COVERAGE INFORMATION (PLEASE COMPLETE THE SECTION BELOW)

Do you or any of your covered dependents have other Medical/Medicare coverage that is primary to the City's Medical Plan? Yes or No
If Yes, Name of Insured: ____________________
Place of Employment: ____________________
Insurance Company: ____________________
Policy #: ____________________
Insurance Company Phone #: ____________________
Insurance Company Address: ____________________

If covered by Medicare, please check what type(s):
☐Part A ☐Part B ☐Both A&B
Reason for Medicare Entitlement:
☐Age ☐Disability ☐End Stage Renal Disease
Medicare HIC #:______________
Medicare Part A Effective Date:_____
Medicare Part B Effective Date:_____

ACKNOWLEDGEMENT AND AUTHORIZATION:

I, _____, hereby certify under penalty of perjury that the information provided in this application for employee benefits, including social security numbers, addresses, spouse and or dependent child(ren) information, is true and correct. I further acknowledge that I understand that providing false information may subject me to a denial of employee benefits, disciplinary action including termination of employment from City of Memphis. I authorize the release of this information to my employer, the City of Memphis, and insurance carriers. In addition:

- I authorize my employer to reduce my salary by pre-tax or after-tax deductions, either prospectively or retroactively, for my elected benefits.
- I agree it is my responsibility to check my earnings statement each month to verify my current benefits enrollments and deductions and to alert Health Wellness and Benefits immediately of any errors. Further, I understand that the City of Memphis may not be able to remedy problems identified beyond 30 days.
- I understand that my benefits can only be changed during the designated annual Open Enrollment period or by written notification to Health Wellness and Benefits within 60 days of a qualified life event.
- I understand it is my responsibility to contact Health Wellness and Benefits within 60 days to remove my ex-spouse from all benefits plans if I divorce or become legally separated.
- I understand that while on an unpaid leave of absence or any unpaid status, I am responsible for paying my benefits premiums. Failure to pay premiums timely may result in cancellation of my benefits and reimbursement of any claims paid to my provider(s) for healthcare, etc.

My signature below indicates I have read and understand the above:

Print Name:	Signature:	Date:	Oracle Employee ID #(Required):

EMPLOYER USE ONLY:

Employee Enrollment Date:	Termination Date:	Employment Status: _Active _COBRA _ NEMP Received By/Date:
Received By/Date:	**Entered By/Date:**	

Working Spouse Verification
2015 Plan Year

Participation in the City of Memphis Medical Plan is limited to full time employees and eligible dependents. In order for a spouse to be an eligible participant in the plan, the spouse may not have access to medical insurance through his/her current employer (except through the City of Memphis), previous employer (except through the City of Memphis) or Medicare. You are still able to enroll your dependent children in the County medical plan regardless of your spouse's status under this restriction. Please contact the Benefits Division if you have any questions.

If, at any point, your spouse ceases to be eligible for his/her employer's medical coverage, he/she may be enrolled under your City of Memphis medical plan coverage. You will have 30 days from the loss of eligibility to enroll your spouse under our plan.

Please complete this Verification and return it with your enrollment materials. If you do not return the Verification, your spouse will not be eligible for coverage. You may not make any changes to your election until the following annual benefit enrollment period unless you experience a qualifying event.

Employee Name: _____ Employee Last 4 of SSN: _____
(Last, First, MI)

Spouse Name: _____ Spouse Last 4 of SSN: _____
(Last, First, MI)

Please read all options and initial the appropriate response:

_____ The spouse listed above is employed by the City of Memphis. (Spouse is an eligible participant)

_____ The spouse listed above does not have medical insurance available through a current employer, a previous employer and is not currently eligible for Medicare. (Spouse is an eligible participant)

_____ The spouse listed above is employed/retired but not eligible for group medical coverage through his/her own employer. (Spouse is an eligible participant)

_____ The spouse listed above is employed or retired and eligible for medical coverage through his/her own employer or Medicare. (Spouse is not an eligible participant)

The undersigned do hereby attest that the above information is true and correct to the best of my knowledge. We acknowledge the City of Memphis reserves the right to request supporting documentation and any proof as it, in its sole discretion, deems necessary in order to verify the representations I have made in this Verification. The undersigned also understand that if my spouse's group medical insurance status changes, it is my responsibility to notify the Benefits Office within 30 days of such change. We further acknowledge that if the spouse listed above is covered under the City of Memphis medical plan and it is later determined that the was eligible for other group medical coverage through his/her employer, that we may be required to repay the cost of any claims incurred or paid under the City's Medical Plan. We further understand that knowingly falsifying this form or making any false statement or representation in connection with this form may result in disciplinary action up to and including termination of employment.

Signature _____ Date _____
Employee

Signature _____ Date _____
Spouse

An open enrollment under another employer's benefit plan is considered a permitted mid-year change in status event under Section 125. If your spouse's open enrollment occurred earlier in the year and your spouse chose not to enroll in coverage for which he/she was eligible for, he/she should contact his/her employer and request to enroll in their employer's benefit plan.

Nicotine Usage/Non-Usage Statement

Beginning January 1, 2015, the surcharge on the medical plan imposed for the use of Nicotine Products is $120 per month per family. To avoid the surcharge, covered participant must not use nicotine products or those who do must enroll in a cessation program offered by Cigna or another approved program by June 30, 2015.

If you do not complete and submit this affidavit by the annual enrollment deadline, October 17, 2014 for active employees, November 14, 2014 for 65 and older retirees and November 21, 2014 for retirees under age 65, a surcharge will be added to your employee contributions if you enroll in the City's medical plan for 2015.

Please complete this Verification and return it by October 17, 2014, with your annual enrollment forms

I, _____, hereby certify that: Please check the applicable box:
(Employee's Full Name)

☐ I and all of my insured dependents do not use nicotine products. I also certify that I have not used any nicotine products in the last 60 days including, but not limited to, pipes, cigarettes, cigars, chewing tobacco, snuff, or any other type of smoking or smokeless tobacco (i.e., one usage of any tobacco product in the last 60 days is tobacco use). By completing this Verification and certifying my non-tobacco user status, I know that I will not be subject to the $120 per month "Nicotine Surcharge" on my medical plan contributions.

☐ I or a covered dependent has used nicotine products in the last six months including, but not limited to, pipes, cigarettes, cigars, chewing tobacco, snuff, or any other type of smoking or smokeless tobacco (i.e., one usage of any tobacco product in the last six months is tobacco use). I understand that I will be subject to the $120 "Nicotine surcharge" on medical plan contributions. To avoid the Nicotine Surcharge I understand that any nicotine users covered under my medical plan must complete a Cessation Program through Cigna, another approved program by June 30, 2015 or obtain the appropriate medical certification. I understand the nature and content of this document, I am aware that if I or a covered dependent uses, or begins the use of nicotine products, at any time from October 17, 2014 through December 31, 2015, and I do not advise the Company of this use within two weeks after it occurs, I will be considered to have falsified information and I may be subject to disciplinary action, up to and including termination, subject to repaying all claims paid under the medical plan and/or I will be subject to the Nicotine Surcharge.

Employee Name: _____ Employee ID: _____ Last 4 of Employee SSN: _____
Please print full name

Employee Signature: _____ Date: _____

Names of covered individuals who use Nicotine Products:
